



ANNUAL CRITICAL CARE MEDICAL CERTIFICATION	
To be completed in the event of chronic illness, life support system or handicap	
<b>Section 1 -To be completed by customer or representative</b>	<b>Date:</b>
Name Last      First      Middle Initial	Account Number
Service Address of Patient	Name of Patient (Last First MI)
City State Zip	Relationship To Patient
Phone Number Home (Include area code)	Phone Number Work (Include area code)
<b>I certify that the information given above is correct and that the patient named resides at the service address shown.</b>	
Customer Signature	Date
<b>UNLESS THIS NOTICE IS COMPLETED AND SIGNED BY A PHYSICIAN AND RETURNED TO METRO WATER SERVICES WITHIN 30 CALENDAR DAYS, SERVICE MAY BE SUBJECT TO DISCONNECTION.</b>	
<b>Section 2 -To be completed by physician</b>	<b>Date</b>
I am a duly licensed physician in the State of Tennessee and my office practice of medicine is located at _____.	
I certify that in my professional opinion the above named patient is seriously ill and afflicted by the following condition which would be <b>aggravated by the absence of water service</b> : _____	
This Condition is permanent _____ Temporary _____ Anticipated Length of Illness _____	
I understand that I may be contacted to provide further verification of these statements.	
Signature Of Physician	Date Signed
License Number	Phone Number

THE CUSTOMER STILL HAS THE RESPONSIBILITY TO MAKE REASONABLE PAYMENTS ON BILLS OWED TO METRO WATER SERVICES.